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501(c)(3) Hospitals and the Community Benefit Standard

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Summary

The recently enacted Patient Protection and Affordable Care Act (PPACA; P.L. 111-148, § 9007) imposes requirements on hospitals with § 501(c)(3) tax-exempt status. Under the act, hospitals will be required to regularly conduct "community health needs assessments" and adopt implementation strategies to meet those needs. They are also required to have written financial assistance and emergency medical care policies that are consistent with standards imposed by the act. Furthermore, hospitals are not able to charge eligible uninsured individuals more than the lowest amounts charged to insured individuals for emergency and other medically necessary care, and they must make reasonable efforts to determine an individual's eligibility for financial assistance before beginning extraordinary collection actions.

The act's requirements appear to reflect concerns that have arisen in recent years about whether non-profit hospitals are providing adequate public benefits to justify their tax-exempt status. Non-profit hospitals are eligible for federal tax-exempt status as charitable organizations described in § 501(c)(3) of the Internal Revenue Code (IRC). Under the "community benefit" standard developed by the IRS, charitable hospitals are judged on whether they provide sufficient health benefits to the community. The IRS has recently developed a new annual reporting requirement (Schedule H of the Form 990) for hospitals to report information regarding their activities.

This report examines the standard under which hospitals qualify for tax-exempt charitable status under federal law, recent inquiries made by Congress and the IRS into whether hospitals are conducting sufficient activities to justify their exemption, and Section 9007 of the Patient Protection and Affordable Care Act. The **Appendix** to the report discusses the new Schedule H in detail.

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Non-profit hospitals receive billions of dollars in governmental subsidies due to their status as charitable organizations.[1] Benefits that arise from this status under federal law include exemption from federal income taxes, eligibility to receive tax-deductible contributions, and authority to use tax-exempt bond financing.[2] In recent years, Congress, the Internal Revenue Service (IRS), and members of the public have questioned whether hospitals are conducting sufficient charitable activities to justify these benefits. In the 111th Congress, the Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama on March 23, 2010 (P.L. 111-148), imposes additional requirements on § 501(c)(3) hospitals.[3]

Standard for § 501(c)(3) Charitable Status

Non-profit hospitals typically qualify for federal tax-exempt status as charitable organizations described in § 501(c)(3) of the Internal Revenue Code (IRC).[4] There is no definition in the tax code for the term "charitable." A regulation promulgated by the Treasury Department provides some guidance, although it does not explicitly address the activities of hospitals. It states that "[t]he term *charitable* is used in section 501(c)(3) in its generally accepted legal sense," and provides examples of charitable purposes, including the relief of the poor or unprivileged; the promotion of social welfare; and the advancement of education, religion, and science.[5]

In the absence of explicit statutory or regulatory requirements applying the term "charitable" to hospitals, it has been left to the IRS to determine the criteria hospitals must meet to qualify as § 501(c)(3) charitable organizations. Over the years, the IRS has developed two distinct standards: the "charity care standard" and the "community benefit standard."

Charity Care Standard

In 1956, the IRS issued Revenue Ruling 56-185, which addressed the requirements a hospital needed to meet in order to qualify for § 501(c)(3) status as a charitable organization.[6] One of these requirements is known as the "charity care standard." The standard required a hospital to provide, to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it. A hospital that expected full payment did not, according to the ruling, provide charity care based on the fact that some patients ultimately failed to pay. The ruling noted that publicly supported community hospitals would normally qualify as charitable organizations because they serve the entire community, and a low level of charity care would not affect a hospital's exempt status if it was due to the surrounding community's lack of charitable demands.

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[1] *See* Congressional Budget Office, NONPROFIT HOSPITALS AND THE PROVISION OF COMMUNITY BENEFITS, Dec. 2006, at 5 (reporting the estimated value of federal and state tax exemptions provided to charitable hospitals in 2002 was $12.6 billion).

[2] *See* IRC §§ 501(a), 170(c)(2), 145.

[3] The act's provisions are codified at IRC §§ 501(r), 4959, and 6033(b)(15).

[4] IRC § 501(c)(3) describes entities "organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition ... or for the prevention of cruelty to children or animals …." Among other criteria, "no part of the [organization's] net earnings … [may] inure[] to the benefit of any private shareholder or individual." Some hospitals may qualify to be § 501(c)(3) educational or scientific organizations. *See* Rev. Rul. 56-185; 1956-1 C.B. 202. Non-profit hospitals might also be able to qualify for exemption as § 501(c)(4) social welfare organizations.

[5] Treas. Reg. § 1.501(c)(3)-1(d)(2).

[6] Rev. Rul. 56-185, 1956-1 C.B. 202.

Community Benefit Standard

In 1969, the IRS issued Revenue Ruling 69-545, which eliminated from Revenue Ruling 56-185 the requirement that a hospital provide free or reduced-cost care.[7] Under the standard developed in Revenue Ruling 69-545, which is known as the "community benefit standard," hospitals are judged on whether they promote the health of a broad class of individuals in the community.

The ruling involved a hospital that only admitted individuals who could pay for the services (by themselves, private insurance, or public programs such as Medicare), but operated a full-time emergency room that was open to everyone. The IRS ruled that the hospital qualified as a charitable organization because it promoted the health of people in its community. The IRS reasoned that because the promotion of health was a charitable purpose according to the general law of charity, it fell within the "generally accepted legal sense" of the term "charitable," as required by Treasury regulation.[8] Expanding on this point, the ruling stated that

> The promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community.[9]

The IRS concluded that the hospital was "promoting the health of a class of persons that is broad enough to benefit the community" because its emergency room was open to all and it provided care to everyone who could pay, whether directly or through third-party reimbursement.[10] Other characteristics of the hospital that the IRS highlighted included the following: its surplus funds were used to improve patient care, expand hospital facilities, and advance medical training, education, and research; it was controlled by a board of trustees that consisted of independent civic leaders; and hospital privileges were available to all qualified physicians.

It appears the community benefit standard was adopted partly in response to the enactment in 1965 of Medicare and Medicaid, which some thought would reduce the need for hospitals to provide charity care.[11] Its adoption by the IRS may also have been a response to concerns about the charity care standard. These concerns were evidenced in a legislative proposal, introduced in the same year Revenue Ruling 69-545 was issued, that would have created an explicit category in IRC § 501(c)(3) for hospitals.[12] The House Report accompanying the bill expressed concern with how the charity care standard was applied in practice:

> In a number of cases internal revenue agents have challenged the exempt status of hospitals on the sole ground that the hospitals are accepting insufficient numbers of patients at no charge or at rates substantially below cost. This has resulted in significant uncertainty as to

[7] Rev. Rul. 69-545, 1969-2 C.B. 117.

[8] *Id*. (citing to Restatement (Second), Trusts, §§ 368, 372; IV Scott on Trusts (3rd ed. 1967), §§ 368, 372).

[9] *Id*. (citing to Restatement (Second), Trusts, § 368, comment (b); § 372, comments (b), (c); IV Scott on Trusts (3rd ed. 1967), §§ 368, 372).

[10] *Id*.

[11] *See* STAFF OF S. COMM. ON FINANCE, 91ST CONG., MEDICARE AND MEDICAID: PROBLEMS, ISSUES, AND ALTERNATIVES, at 56 (Comm. Print 1970) [hereinafter *Staff Report*].

[12] Tax Reform Act of 1969, H.R. 13270, 91st Cong. (1969) (enacted into law, P.L. 91-172, without the hospital provision).

> the extent to which a hospital must accept patients who are unable to pay, in order to retain its exempt status.[13]

Shortly after the House Report was released, the IRS issued Revenue Ruling 69-545. The Senate Finance Committee then removed the hospital provision from the bill, noting the existence of the new ruling and stating it would look at the issue when it addressed pending Medicare and Medicaid legislation.[14] A subsequent Finance Committee staff document on Medicare and Medicaid issues advocated that the ruling be revoked and the charity care standard be reimposed until Congress could address the situation.[15]

Legal Challenge to the Community Benefit Standard

After the release of Revenue Ruling 69-545, several indigents and organizations with indigent members filed a class action suit challenging the IRS's authority to implement the community benefit standard, which they argued was inconsistent with the term "charitable" in IRC § 501(c)(3) because it did not require treatment of the poor. The Supreme Court ordered the district court to dismiss the case because the plaintiffs lacked the constitutionally required standing to bring suit.[16] To have standing, "[a] plaintiff must allege personal injury fairly traceable to the defendant's allegedly unlawful conduct and likely to be redressed by the requested relief."[17] The plaintiffs' alleged injury was that the adoption of the community benefit standard had encouraged hospitals to not provide necessary medical care to the indigents. The Court, in holding the plaintiffs lacked standing, reasoned that it was "purely speculative" as to whether the hospitals had denied treatment because of the new ruling and not for other reasons and whether the plaintiffs' success would result in care being provided since hospitals could choose to give up their tax-exempt status if the cost was too high.[18]

Further Development of the Community Benefit Standard

The IRS continues to use and develop the community benefit standard. In 1983, the IRS issued Revenue Ruling 83-157, which clarifies the requirement that a hospital operate an emergency room that is open to the public.[19] While an important factor in Revenue Ruling 69-545 was that the hospital operated an emergency room open to everyone, Revenue Ruling 83-157 states that a hospital without an emergency room may still qualify for exempt status if other conditions are

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[13] H.Rept. 91-413, pt. 1, at 43 (1969).

[14] S.Rept. 91-552, at 61 (1969).

[15] *See Staff Report*, *supra* note 11, at 56 ("The staff strongly recommends revocation of Revenue Ruling 69-545 in light of the recent legislative history and continuation of the prior position of the Service until such time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients").

[16] Simon v. E. Ky. Welfare Rights Org., 426 U.S. 26 (1976). The plaintiffs had prevailed before the district court, which had voided Revenue Ruling 69-545 as being "improperly promulgated" since there was insufficient justification for the "clear change of previously administered policy." E. Ky. Welfare Rights Org. v. Shultz, 370 F. Supp. 325, 336-38 (D.D.C. 1973). The D.C. Circuit Court of Appeals reversed, finding the IRS interpretation of "charitable" was permissible because the term's definition "has never been static and has been broadened in recent years" and "is thus capable of a definition far broader than merely the relief of the poor." E. Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278, 1286-90 (D.C. Cir. 1974). The court reasoned that limiting the term to relief of the poor "fails to recognize the changing economic, social and technological precepts and values of contemporary society." *Id*. at. 1288.

[17] Allen v. Wright, 468 U.S. 737, 751 (1984).

[18] E. Ky. Welfare Rights Org., 426 U.S. at 42, 43.

[19] Rev. Rul. 83-157, 1983-2 C.B. 94.

met. The ruling recognized there are circumstances in which hospitals may not need to operate emergency rooms, such as when a state agency has determined that its operation would be duplicative or when a hospital is in a specialized field that is unlikely to require emergency care. In these situations, a hospital may still qualify as a charitable organization if it shows other evidence that it provides benefits to the community by promoting the health of a broad class of persons. The ruling listed examples of factors that may be used as evidence: a board of directors chosen from members of the community; an open medical staff policy; treatment of patients using public programs (e.g., Medicare and Medicaid); and using surplus funds for improving patient care, facilities, equipment, and medical training, education, and research.

Recent Controversy

In the past several years, questions have arisen as to whether non-profit hospitals deserve the benefits they receive as § 501(c)(3) charitable organizations.[20] Areas of controversy include the prices charged to low-income uninsured patients for medical care in comparison to those charged patients paying through insurance; the methods used by hospitals to collect payment from patients and the classification of bad debt as a community benefit; an increasing number of partnerships between tax-exempt hospitals and for-profit entities; and the amount of compensation paid to high-level employees. Additionally, some have questioned whether the community benefit standard is correct, or whether tax-exempt hospitals should categorically be required to provide a certain level of charity care.

In 2004 and 2005, class action lawsuits were filed in at least 25 states challenging the treatment and billing practices of § 501(c)(3) hospitals with respect to low-income uninsured individuals.[21] One claim made by the plaintiffs was that IRC § 501(c)(3) created a contract between the federal government and hospitals or a charitable trust for the public's benefit, either of which required hospitals to provide emergency treatment to patients regardless of their ability to pay, charge affordable and fair prices, and not engage in abusive collection practices. Courts disagreed, finding that the statute clearly neither creates a contract or charitable trust, nor provides third-party beneficiaries with a private cause of action.[22]

Congressional Activity in the 109th and 110th Congresses

Over the past several years, the activities of § 501(c)(3) hospitals have received congressional attention. For example, in the 109th Congress, the House Ways and Means and Senate Finance Committees held hearings on tax-exempt hospitals.[23] Additionally, then-Chairman Thomas of the

[20] *See, e.g.,* John Carreyrou and Barbara Martinez, *Nonprofit Hospitals, Once For the Poor, Strike It Rich; With Tax Breaks, They Outperform For-Profit Rivals*, WALL ST. J., Apr 4, 2008, at A.1.

[21] *See, e.g.,* McCoy v. E. Tex. Med. Ctr. Reg'l Healthcare Sys., 388 F. Supp. 2d 760 (E.D. Tex. 2005); Valencia v. Miss. Baptist Med. Ctr., Inc., 363 F. Supp. 2d 867 (S.D. Miss. 2005); Amato v. UPMC, 371 F. Supp. 2d 752 (W.D. Penn. 2004); Ferguson v. Centura Health Corp., 358 F. Supp. 2d 1014 (D. Colo. 2004); Quinn v. BJC Health Sys., 364 F. Supp. 2d 1046 (E.D. Mo. 2005). The Judicial Panel for Multidistrict Litigation denied a motion to consolidate the cases. *See In re* Not-for-Profit Hospitals/Uninsured Patients Litigation, 341 F. Supp. 2d 1354 (J.P.M.L. Oct. 19, 2004).

[22] *See, e.g.,* Kolari v. New York-Presbyterian Hosp., 382 F. Supp. 2d 562, 565-56 (S.D.N.Y. Mar. 29, 2005), *vacated, in part, and remanded*, 455 F.3d 118 (2d Cir. 2006) ("Plaintiffs here have lost their way; they need to consult a map or a compass or a Constitution because Plaintiffs have come to the judicial branch for relief that may only be granted by the legislative branch.").

[23] *Hearing on the Tax-Exempt Hospital Sector before the House Committee on Ways and Means*, 109th Cong. (2005), available at http://waysandmeans.house.gov/hearings.asp?formmode=detail&hearing=415; *Taking the Pulse of Charitable Care and Community Benefits at Nonprofit Hospitals: Hearing before the Senate Committee on Finance*,

Ways and Means Committee introduced the Tax Exempt Hospitals Responsibility Act of 2006 (H.R. 6420, 109th Congress). Under the bill, a hospital would have only been eligible for § 501(c)(3) status if it (1) adopted policies and procedures, consistent with requirements imposed by the act, for providing and charging for medically necessary care to low-income uninsured individuals, and (2) normally operated in a manner consistent with those policies and procedures. No action was taken on the bill.

In the 110th Congress, the minority staff on the Senate Finance Committee released a discussion draft of possible tax-exempt hospital reforms and invited public comment on them.[24] Among the proposals put forth in the discussion draft were a requirement that each hospital maintain and publicize a charity care program and provide minimum amounts of charity care measured as a percentage of that hospital's total operating expenses. At the request of Senator Grassley, the Government Accountability Office (GAO) issued a report that examined how the discretion afforded hospitals under federal law in determining their community benefit activities and the wide variety in state community benefit requirements have led to inconsistencies in the way community benefits are defined and measured.[25]

Recent IRS Activity and Schedule H of Form 990

In 2006, the IRS sent questionnaires to approximately 600 large hospitals to collect information on how hospitals operated (e.g., billing practices, emergency room availability, and compensation) and what types of community benefits they provided.[26] Amid concerns about "whether there [were] differences between for-profit and tax-exempt hospitals,"[27] the IRS announced that hospitals would be required to provide additional information specific to their industry on a new Schedule H of the redesigned Form 990 (the annual information return filed by tax-exempt organizations).[28] Schedule H was drafted to "combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care."[29]

Schedule H contains six parts, which are discussed in detail in the **Appendix**. Part I requests details about a hospital's charity care program and attempts to quantify charity care expenditures. Part II quantifies the hospital's community building activities. Part III quantifies the costs due to Medicare shortfalls and bad debts owed to the organization. Part IV requires disclosure of any joint ventures in which a hospital participates. Part V requests information about the entity's

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109th Cong. (2006), available at http://finance.senate.gov/sitepages/hearing091306.htm.

[24] Senate Finance Committee Minority Staff, *Tax-Exempt Hospitals: Discussion Draft* (2007), available at http://finance.senate.gov/press/Gpress/2007/prg071907a.pdf.

[25] U.S. Government Accountability Office, *Nonprofit Hospitals: Variation in Standards and Guidance Limits Comparison of How Hospitals Meet Community Benefit Requirements*, GAO-08-880, Sept. 2008. Some states have adopted charity care or community benefit requirements as a condition imposed to receive state tax exemption or for regulatory purposes. *See id., see also* Community Catalyst, Inc., *Health Care Community Benefits: A Compendium of State Laws*, available at http://www.communitycatalyst.org/doc_store/publications/community_benefits_compendium_2007.pdf.

[26] The questionnaire is available on the IRS website at http://www.irs.gov/pub/irs-tege/exhibit_1__form13790.pdf. The IRS's final report on the compliance project is available at http://www.irs.gov/pub/irs-tege/frepthospproj.pdf.

[27] IRS, *Draft Form 990 Redesign Project - Schedule H: Instructions*, at 1, June 14, 2007, available at http://www.irs.gov/pub/irs-tege/draftform990redesign_schh_instr.pdf [hereinafter *June 14 Draft Comments*].

[28] IRS, Press Release, *IRS Releases Final 2008 Form 990 for Tax-Exempt Organizations, Adjusts Filing Threshold to Provide Transition Relief*, Dec. 20, 2007, available at http://www.irs.gov/newsroom/article/0,,id=176722,00.html. The new Schedule H is part of a significant redesign of the entire Form 990.

[29] *June 14 Draft Comments*, *supra* note 27, at 1.

health care facilities. Part VI provides an area in which to discuss, in a narrative fashion, other charitable activities that may be difficult to quantify. For tax year 2008, the only portion of Schedule H that was required was the disclosure and description of the hospital facilities operated by the filing entity. The entire Schedule is mandatory beginning with tax year 2009.

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA; P.L. 111-148, § 9007) imposes additional requirements on hospitals in order to qualify for § 501(c)(3) status. The requirements apply to organizations operating a facility that must be licensed, registered, or similarly recognized as a hospital under state law and any other organization determined by the Treasury Secretary to have the provision of hospital care as its principal § 501(c)(3) tax-exempt function or purpose.[30] An organization with multiple facilities must meet the requirements for each facility and will not be treated as a § 501(c)(3) organization with respect to any facility for which the requirements are not met.

The act imposes four new requirements.[31] First, starting with taxable years beginning after March 23, 2012, hospitals will be required to conduct a "community health needs assessment" in the current or past two taxable years and adopt an implementation strategy to meet those needs.[32] The assessment must be made publicly available and take into account input from persons representing the broad interests of the community, including those with public health knowledge or expertise. An organization that fails to meet the assessment requirement for the taxable year will be subject to a new excise tax equal to $50,000.[33] Additionally, hospitals will be required to describe on the Form 990 how the needs identified in the assessment are being met and explain why any identified needs are not being addressed.[34]

Second, starting with taxable years beginning after March 23, 2010, hospitals are required to have written financial assistance and emergency medical care policies.[35] The financial assistance policy must address eligibility criteria for financial assistance, the application process, and whether the assistance includes free or discounted care. Other issues that must be addressed include the basis for calculating amounts charged to patients, the actions that might be taken for nonpayment (e.g., collection actions and reporting to credit agencies),[36] and the hospital's measures to widely publicize the policy within the community. The emergency medical care policy must require the hospital to provide, "without discrimination," care for emergency medical conditions[37] to individuals regardless of their eligibility for financial assistance.

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[30] IRC § 501(r)(2).

[31] IRC § 501(r)(1).

[32] IRC § 501(r)(3).

[33] IRC § 4959.

[34] IRC § 6033(b)(15). Hospitals will also be required to provide audited financial statements with the Form 990 and disclose amounts paid under the new excise tax.

[35] IRC § 501(r)(4).

[36] This information is only required if the hospital does not have a separate billing and collections policy.

[37] Emergency medical conditions are defined with reference to § 1867 of the Social Security Act (42 U.S.C. § 1395dd) also known as the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA currently defines emergency medical conditions as any situation in which the absence of immediate medical care would jeopardize the patients health or lead to serious bodily impairment or dysfunction. This definition also explicitly includes women in labor where there is insufficient time to safely transfer the mother to another facility. 42 U.S.C. § 1395dd(e)(1). Under EMTALA, all Medicare participating hospitals that operate an emergency room, whether tax-exempt or not, are

Third, with respect to emergency and other medically necessary care, hospitals may not charge individuals eligible under the financial assistance policy more than the lowest amounts charged to those with insurance coverage.[38] Hospitals are also prohibited from using gross charges. These rules apply to taxable years beginning after March 23, 2010.

Fourth, hospitals are required to make reasonable efforts to determine whether an individual is eligible for financial assistance before beginning extraordinary collection actions.[39] This provision applies to taxable years beginning after March 23, 2010.

The Treasury Department is directed to issue necessary regulations and guidance, including guidance on whether a hospital has made reasonable efforts to determine a patient's eligibility under its financial assistance policy.[40] An official at the Treasury Department has been quoted as saying that guidance on the act's provisions is needed "sooner rather than later," although she did not offer specifics.[41]

Under the act, the Treasury Secretary will also be required to review, at least once every three years, the community benefit activities of any hospital subject to the new requirements.[42] Additionally, he or she, in consultation with the Secretary of Health and Human Services (HHS), will be required to annually provide Congress with information on the charity care, bad debt expenses, and unreimbursed costs for services provided under means and non-means tested government programs of private tax-exempt, taxable, and government-owned hospitals, in addition to the costs of community benefit activities by private tax-exempt hospitals.[43] A report on trends in this information is due within five years of the act's enactment.

required to screen all incoming patients and stabilize emergency medical conditions regardless of ability to pay. For more information, *see* CRS Report RS22738, *EMTALA: Access to Emergency Medical Care*, by Edward C. Liu.

[38] IRC § 501(r)(5).

[39] IRC § 501(r)(6).

[40] IRC § 501(r)(7).

[41] Simon Brown, *Guidance Needed on New Charitable Hospital Provisions, Treasury Official Says*, TAX NOTES (May 3, 2010).

[42] PPACA, § 9007(c).

[43] PPACA, § 9007(e). The reports will go to the House Committees on Ways and Means, Education and Labor, and Energy and Commerce, and the Senate Committees on Finance and Health, Education, Labor, and Pensions.

Appendix. Schedule H

As discussed in this report, hospitals with tax-exempt status are now required to provide information specific to their industry on the new Schedule H of the redesigned Form 990 (the annual information return filed by tax-exempt organizations).[44] The IRS released a draft Schedule H in June 2007 and, after seeking public comment on the draft, issued the final version in December 2007. Drawn heavily from, but not identical to, the community benefit reporting model used by the Catholic Health Association of the United States (CHA), Schedule H was drafted to "combat the lack of transparency surrounding the activities of tax-exempt organizations that provide hospital or medical care."[45]

Comments on the draft expressed immediate concerns about the technical and procedural implications of the addition. For example, comments reflected uncertainty over what constituted a hospital and whether multiple iterations of the Schedule were required for entities operating more than one hospital facility. In response, the IRS indicated that it intended to defer to state law for the definition of hospitals and that only one Schedule H would be required for an entity with a single employer identification number, regardless of the number of hospitals run by it.[46]

Schedule H contains six parts, each of which will be discussed in detail below. Part I requests details about a hospital's charity care program and attempts to quantify charity care expenditures. Part II quantifies the hospital's community building activities. Part III quantifies the costs due to Medicare shortfalls and bad debts owed to the organization. Part IV requires disclosure of any joint ventures in which a hospital participates. Part V requests information about the entity's health care facilities. Part VI provides an area in which to discuss, in a narrative fashion, other charitable activities that may be difficult to quantify.

Part I: Quantifying the "Community Benefit" Standard

Part I attempts to quantify the amount of community benefit provided by hospitals on an annual basis. The metric the IRS has chosen to quantify community benefit is dollars spent. Qualifying expenses include free care, unreimbursed Medicaid, unreimbursed costs from other means tested government programs,[47] community health improvement services,[48] health professions education,[49] subsidized health services,[50] research,[51] and contributions to other community groups.[52]

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[44]Schedule H is available at http://www.irs.gov/pub/irs-pdf/f990sh.pdf (hereinafter *Schedule H*).

[45] *June 14 Draft Comments*, *supra* note 27, at 1.

[46] IRS, *Form 990 Redesign for Tax Year 2008 Schedule H, Hospitals—Highlights*, at 2, Dec. 20, 2007, available at http://www.irs.gov/pub/irs-tege/highlights_schedule_h.pdf [hereinafter *Dec. 20 Draft Highlights*]. *See also* IRS, *Schedule H (Form 990) Instructions*, at 1, available http://www.irs.gov/pub/irs-pdf/i990sh.pdf [hereinafter *Schedule H Instructions*].

[47] Other means tested programs includes SCHIP and other federal, state, or local health care programs where "eligibility depends on the recipient's income or asset level." *Schedule H Instructions*, *supra* note 46, at 9.

[48] Community health improvement services must be supported by a documented "community need." *Id.* at 10.

[49] Costs for medical residents and interns may be included as health professions education costs. *Id.* at 11.

[50] Subsidized health services must be supported by a documented "community need." *Id.* at 13.

[51] Research funded by tax-exempt or government sources, including internally funded research, may be reported here. Research funded by other entities may not be reported as community benefit, but can be listed under Part VI of Schedule H. *Id.* at 14.

[52] *Schedule H*, *supra* note 44, at Part I.

Aside from concerns about the technical aspects of the new Schedule H, several substantive criticisms also emerged from the public comments. For the most part, these criticisms stemmed from the perception that the categories of charity care and community benefit envisioned by the IRS were underinclusive.[53] The agency had explicitly stated in its comments accompanying the initial draft of Schedule H that the Schedule was an attempt to "quantify, in an objective manner, the community benefit standard applicable to tax-exempt hospitals."[54] While the IRS did not suggest a minimum level of expenditures that would be required in order to justify tax-exemption, it is probable that some hospitals were concerned that the exclusion of certain expenditures would make themselves appear, on paper, undeserving of tax-exempt status. By and large, these criticisms focused on three specific omissions: community building expenditures, Medicare shortfalls, and bad debt.

Part II: Community Building

Schedule H includes an area, Part II, in which to report community building expenditures. Although the definition of "community building" may not be obvious at first glance, it is generally understood to refer to programs that are intended to have a beneficial impact upon the health of a community but that do not provide medical care.[55] Examples of community building are housing improvements, economic development, community support, environmental improvements, leadership development, coalition building, community health improvement advocacy, and workforce development.[56]

The initial draft of Schedule H did not include community building activities in its calculation of community benefit. In comments on the draft, the CHA strongly opposed their exclusion. The CHA argued that "there is clear consensus in the public health community that social and environmental factors are strong determinants of health for vulnerable populations," citing publications from the Centers for Disease Control and Prevention and other scholarly articles.[57] Additionally, the CHA noted that "every community building activity would qualify for exemption on a stand-alone basis."[58]

Despite the subsequent inclusion of community building metrics on the Schedule H, these numbers are still separate from the reporting of charity care and community benefit expenditures in Part I. The IRS commentary on the Schedule's final draft reflected the view that the link between community building and health was still tenuous and that the reporting tools in Schedule H are intended to operate, in part, as data collection methods for the IRS to discern what links exist.[59]

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[53] *See, e.g.*, American Hospital Association, *Comments on Draft Schedule H*, at 2-4, Aug. 21, 2007 [hereinafter AHA Comments]; Catholic Health Association of the United States, *Comments Related to Schedule H*, at 4, Sept. 12, 2007, [hereinafter CHA Comments]; Health Law and Taxation Sections of the American Bar Association, *Comments Concerning Discussion Draft of Redesigned Form 990 for Tax-exempt Organizations*, at 66-69, Oct. 4, 2007 [hereinafter ABA Comments].

[54] *June 14 Draft Comments*, *supra* note 27, at 1.

[55] *See, e.g.*, AHA Comments, *supra* note 53, at 7; CHA Comments, *supra* note 53, at 8; ABA Comments, *supra* note 53, at 69.

[56] *Schedule H*, *supra* note 44, at Part II.

[57] CHA comments, *supra* note 53, at 9.

[58] *Id.* at 10.

[59] *Dec. 20 Draft Highlights*, *supra* note 46, at 4.

Part III: Medicare Shortfalls

Hospitals incur costs when treating all patients, including patients who are covered by Medicare. Medicare, however, may not reimburse a provider for the total cost of services received by a patient. The difference between the Medicare reimbursement rates and the costs incurred by a hospital are called shortfalls.

Some commentators on the draft Schedule H expressed a belief that a hospital should be allowed to include the aggregate amount of these shortfalls in any calculation of the total community benefit provided by that hospital. For example, comments from the Health Law and Taxation Sections of the American Bar Association (ABA) reasoned that "the entire amount of any 'Medicare shortfall' should count as 'charity care,' because the elderly constitute a clearly recognized charitable class."[60] Additionally, the American Hospital Association (AHA) commented that "many Medicare beneficiaries, like their Medicaid counterparts, are poor," and would have qualified for a hospital's charity care program or Medicaid in addition to Medicare.[61] If these patients had been treated as charity care, the entire cost of medical care would have been considered community benefit under Part I. Additionally, any shortfall in Medicaid reimbursement would similarly have been included in community benefit.

Others, however, argued that Medicare shortfalls are not a useful metric for determining community benefit. The Catholic Health Association, opposing inclusion, noted that "many for-profit hospitals compete aggressively for these [Medicare] patients."[62] In its view, measuring Medicare shortfalls would not usefully distinguish for-profit hospitals from those seeking tax exemption, and creating distinctions between these two groups is necessary to ensure that tax exemption retains its credibility with policy makers. Notwithstanding these arguments, the CHA noted that "if, at some point, access problems emerge for Medicare patients, the rationale for including Medicare services as community benefit increases."[63]

Schedule H includes a dedicated area in which to report Medicare shortfalls. Despite the addition of Part III, the IRS does not treat Medicare shortfalls as a direct measure of community benefit, in and of themselves. Instead, hospitals are asked to "[d]escribe ... the extent to which any shortfall reported in [this part] *should* be considered as community benefit."[64]

Part III (continued): Bad Debt

Hospitals regularly engage in billing and collection practices in order to recoup co-pays, deductibles, and other expenses from patients. During the collection process, there may occur a point at which it becomes apparent that a debt owed to the hospital has little or no potential of repayment. In accordance with sound accounting practices, it is customary to "write off" these debts as "bad debt."

Because bad debts, by definition, represent services hospitals have provided without compensation, some believe that the aggregate amount of bad debt should be included in any calculation of community benefit. Community benefit in the context of the provision of health

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[60] ABA Comments, *supra* note 53, at 66 (citing Rev. Rul. 1972-124, 1972-1 C.B. 145).

[61] AHA Comments, *supra* note 53, at 5.

[62] CHA Comments, *supra* note 53, at 14. The discussion of Medicare shortfalls may also raise the question whether shortfalls in reimbursement from *for-profit* insurers should also be counted as uncompensated care.

[63] *Id.*

[64] *Schedule H, supra* note 44, at Part III (emphasis added).

care services normally refers to means-tested eligibility programs, but the ABA noted that "hospitals continue to have difficulty separating traditional uncompensated care from true bad debt" due to "issues associated with identifying individuals who qualify for uncompensated care."[65] Some portion of bad debt, therefore, appears to include the provision of care to individuals who would have been eligible for charity care.[66] Proponents argue that it is unfair to penalize a hospital with a reduced community benefit calculation simply because the charity care program did not accurately classify these individuals.[67]

Support for inclusion of bad debt was not universal among the comments submitted. The Catholic Health Association noted that bad debt is a "'cost of doing business' that affects taxable and tax-exempt organizations."[68] In CHA's opinion, reporting bad debt does not create meaningful distinctions between for-profit and non-profit entities that would justify tax exemption.[69] CHA did not necessarily dispute the theory that bad debt includes some patient charges that should be considered charity care. Rather, CHA argued that hospitals should improve their charity care programs to identify these patients at the onset of treatment, rather than using bad debt to approximate the impact of these patients after the fact.[70] In support of this argument, CHA also noted that "many Catholic hospitals have changed their policies and improved their ability to identify patients eligible for financial assistance."[71] Some patient advocates have also noted the perceived inequity in allowing hospitals to benefit from bad debt after instituting potentially aggressive and damaging collection practices against patients.[72]

Schedule H allows hospitals to report bad debt in Part III alongside Medicare shortfalls, but bad debt expense may not be reported on the charity care and community benefit table.[73] As with Medicare shortfalls, filing hospitals will have to explain what portion of bad debt should be considered community benefit.[74] The IRS comments accompanying the Schedule's final draft indicated that it does not intend to automatically consider any portion of bad debt a community benefit, citing a lack of consensus regarding bad debt policies among hospitals.[75]

Part IV: Management Companies and Joint Ventures

Part IV of Schedule H asks tax-exempt entities that operate hospitals to list the joint ventures they participate in. Joint ventures can be problematic in the non-profit healthcare context for a variety of reasons. If physicians with staff privileges at the hospital also have a proprietary interest in the joint venture, referrals to that joint venture may violate federal prohibitions against self-referrals

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[65] ABA Comments, *supra* note 53, at 66.

[66] Uninsured or under-insured patients that cannot afford to pay are nevertheless charged, and that inevitably leads to bad debt precisely because they cannot afford to pay.

[67] One alternative put forth by the ABA is to include some percentage of bad debt, in proportion to the amount of bad debt universally in a given region, as community benefit. ABA Comments, *supra* note 53, at 67.

[68] CHA comments, *supra* note 53, at 15.

[69] *Id.*

[70] *Id.* at 14-15.

[71] *Id.* at 15.

[72] *See, e.g.*, Lucette Lagnado, *Twenty Years and Still Paying: Jeanette White is Long Dead But Her Hospital Bill Lives On*, WALL ST. J., Mar. 13, 2003, at B1.

[73] *Schedule H, supra* note 44, at Part III; *Schedule H Instructions*, *supra* note 44, at 3.

[74] *Schedule H, supra* note 44, at Part III.

[75] *Dec. 20 Draft Highlights*, *supra* note 46, at 3.

or kickbacks.[76] If directors or trustees of the hospital have a proprietary interest in that joint venture, the non-profit status of the hospital could be jeopardized by any benefit that they receive as a result of their interest in the venture.[77] Similarly, in *St. David's Health Care System v. United States*, the Fifth Circuit held that a joint venture's profit motive could undermine a non-profit partner's status as a charitable organization.[78]

For the most part, these issues are common to all tax-exempt organizations. The majority of comments addressing this issue noted that the IRS already receives information on joint ventures in the redesigned Form 990, and that only organizations that operate hospitals are burdened with this extra reporting requirement in Schedule H.[79] In response, the IRS noted that the "unique relationship between hospitals and physicians resulting from their special status of having medical staff privileges without regard to employment appears to have no clear analogy in other exempt organization contexts."[80] The IRS did limit this reporting requirement to those joint ventures where directors, trustees, and physicians with staff privileges together owned at least 10% of the joint venture.

Part V: Facility Information

Organizations are asked, in Part V of Schedule H, to identify all hospital or medical care facilities and to indicate the types of medical services provided by each. The definition of hospital or medical care does *not* include assisted living services, vocational training for the disabled, or medical education and research.[81]

Part VI: Supplemental Information

Part VI of Schedule H provides an area in which to provide narrative information regarding the amount of community benefit provided. The IRS stated that this area could be used to explain why some portion of Medicare shortfall or bad debt reported in other areas of the Schedule should be considered community benefit.[82] In addition, hospitals may provide details about other community benefits they provide that are not easily quantifiable.[83]

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[76] For a more detailed discussion of physician self-referral and federal law, *see* CRS Report RL32494, *Medicare: Physician Self-Referral ("Stark I and II")*, by Jennifer O'Sullivan.

[77] Under IRC § 501(c)(3), the net earnings of a charitable organization may not flow to the benefit of any private shareholder or individual.

[78] St. David's Health Care System v. United States, 349 F.3d 232, 237 (5th Cir. 2003).

[79] *See, e.g.*, AHA Comments, *supra* note 53, at 8-9; CHA Comments, *supra* note 53, at 12-13; ABA Comments, *supra* note 53, at 73.

[80] *Dec. 20 Draft Highlights*, *supra* note 46 at 5.

[81] *June 14 Draft Comments*, *supra* note 27, at 8.

[82] *Dec. 20 Draft Highlights*, *supra* note 46, at 5.

[83] *Id.*; *see also* Schedule H, *supra* note 44, at Part VI.

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